

		FOR OHF USE					

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**2004**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2004)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0005462</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>The Arthur Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>09/01/2003</u> to <u>08/31/2004</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
<b>Address:</b> <u>423 Eberhardt Drive</u> <u>Arthur</u> <u>61911</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
<b>County:</b> <u>Moultrie</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____	
<b>Telephone Number:</b> <u>(217) 543-2103</u> <b>Fax #</b> <u>(217) 543-2278</u>		<b>Paid Preparer</b> (Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u> (Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u>	
<b>IDPA ID Number:</b> <u>370794402001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
<b>Date of Initial License for Current Owners:</b> <u>1/1/1958</u>			
<b>Type of Ownership:</b>			
<input checked="" type="checkbox"/> <b>VOLUNTARY, NON-PROFIT</b>			
<input checked="" type="checkbox"/> Charitable Corp.			
<input type="checkbox"/> Trust			
<b>IRS Exemption Code</b> <u>501(c)(3)</u>			
<input type="checkbox"/> <b>PROPRIETARY</b>			
<input type="checkbox"/> Individual			
<input type="checkbox"/> Partnership			
<input type="checkbox"/> Corporation			
<input type="checkbox"/> "Sub-S" Corp.			
<input type="checkbox"/> Limited Liability Co.			
<input type="checkbox"/> Trust			
<input type="checkbox"/> Other _____			
<b>GOVERNMENTAL</b>			
<input type="checkbox"/> State			
<input type="checkbox"/> County			
<input type="checkbox"/> Other _____			
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>Michael W. Martin</u> <b>Telephone Number:</b> <u>(217) 753-3858</u> Please send copies of desk review and audit adjustments to address on this page			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arthur Home# 0005462 Report Period Beginning: 09/01/2003 Ending: 08/31/2004

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>69</u>	Skilled (SNF)	<u>69</u>	<u>25,254</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>69</u>	TOTALS	<u>69</u>	<u>25,254</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>621</u>	<u>30</u>	<u>2,600</u>	<u>3,251</u>	8
9	SNF/PED					9
10	ICF	<u>9,071</u>	<u>12,268</u>		<u>21,339</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,692</u>	<u>12,298</u>	<u>2,600</u>	<u>24,590</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 97.37%

D. How many bed-hold days during this year were paid by Public Aid?

2 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been  
eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒NO ☐

I. On what date did you start providing long term care at this location?

Date started 01/01/1958

J. Was the facility purchased or leased after January 1, 1978?

YES ☐Date N/ANO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 69and days of care provided 2,600Medicare Intermediary Mutual of Omaha

## IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH\* ☐CASH\* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 08/31/04 Fiscal Year: 08/31/04

\* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number The Arthur Home

# 0005462

Report Period Beginning: 09/01/2003

Ending: 08/31/2004

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	168,284	10,197	12,068	190,549		190,549		190,549			1
2	Food Purchase		121,750		121,750		121,750	(3,656)	118,094			2
3	Housekeeping	73,842	10,804	1,100	85,746		85,746		85,746			3
4	Laundry	64,327	7,916		72,243		72,243		72,243			4
5	Heat and Other Utilities			61,768	61,768		61,768		61,768			5
6	Maintenance	44,139		49,876	94,015		94,015		94,015			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	350,592	150,667	124,812	626,071		626,071	(3,656)	622,415			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			4,000	4,000		4,000		4,000			9
10	Nursing and Medical Records	991,455	54,105	4,172	1,049,732		1,049,732		1,049,732			10
10a	Therapy			79,926	79,926		79,926		79,926			10a
11	Activities	114,511	9,105	3,144	126,760		126,760	(17,597)	109,163			11
12	Social Services											12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	1,105,966	63,210	91,242	1,260,418		1,260,418	(17,597)	1,242,821			16
	<b>C. General Administration</b>											
17	Administrative	73,839			73,839		73,839		73,839			17
18	Directors Fees											18
19	Professional Services			15,261	15,261		15,261		15,261			19
20	Dues, Fees, Subscriptions & Promotions			13,377	13,377		13,377	(2,054)	11,323			20
21	Clerical & General Office Expenses	63,105	16,413	16,276	95,794		95,794	(975)	94,819			21
22	Employee Benefits & Payroll Taxes			288,571	288,571		288,571		288,571			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,419	10,419		10,419		10,419			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			59,788	59,788		59,788		59,788			26
27	Other (specify):*											27
28	<b>TOTAL General Administration</b>	136,944	16,413	403,692	557,049		557,049	(3,029)	554,020			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,593,502	230,290	619,746	2,443,538		2,443,538	(24,282)	2,419,256			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name &amp; ID Number

The Arthur Home

#0005462

Report Period Beginning:

09/01/2003

Ending:

08/31/2004

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			70,756	70,756		70,756		70,756			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,569	1,569		1,569	(1,569)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			72,325	72,325		72,325	(1,569)	70,756			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		69,508		69,508		69,508		69,508			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			37,778	37,778		37,778		37,778			42
43	Other (specify):* <b>Nonallowable Costs</b>			29,981	29,981		29,981	(29,981)				43
44	<b>TOTAL Special Cost Centers</b>		69,508	67,759	137,267		137,267	(29,981)	107,286			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,593,502	299,798	759,830	2,653,130		2,653,130	(55,832)	2,597,298			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

\*\*See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

	1	2	3	
	Amount	Refer-	OHF USE	
		ence	ONLY	
<b>NON-ALLOWABLE EXPENSES</b>				
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(3,625)	2		4
5 Telephone, TV & Radio in Resident Rooms	(4,588)	43		5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation				9
10 Interest and Other Investment Income				10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(222)	43		13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions	(250)	43		20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotional				25
Income Taxes and Illinois Personal				
26 Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule See Pg5A	(47,147)	various		29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (55,832)		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)			34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B) )	\$ (55,832)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		x	\$		38
39					39
40 Gift and Coffee Shops		x			40
41 Barber and Beauty Shops		x			41
42 Laboratory and Radiology		x			42
43 Prescription Drugs		x			43
44 Exceptional Care Program		x			44
45 Other-Attach Schedule		x			45
46 Other-Attach Schedule		x			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

The Arthur Home

ID# 0005462

Report Period Beginning: 09/01/2003

Ending: 08/31/2004

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Disallow X-ray - Medicare	\$ (3,871)	43	1
2	Disallow Lab - Medicare	(3,800)	43	2
3	Disallow House & Farm Property expenses:			3
4	Depreciation	(2,735)	43	4
5	Legal/Prof/Maint	(55)	43	5
6	Disallow Eberhardt Village expenses:			6
7	Purchases Services	(120)	43	7
8	Office Supplies	(152)	43	8
9	Educational Expense	(1,180)	43	9
10	Legal/Prof	(1,871)	43	10
11	House/Farm Taxes	(5,910)	43	11
12	Utilities	(5,227)	43	12
13	Disallow Chamber of Commerce dues	(35)	20	13
14	Offset interest income against related expense	(1,569)	32	14
15	Offset vending income against related expense	(31)	2	15
16	Offset activity income against related expense	(4,362)	11	16
17	Offset transportation income against expense	(13,235)	11	17
18	Offset other income against related expense	(500)	21	18
19	Disallow advertising	(2,494)	20	19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(47,147)		49

SEE ACCOUNTANTS' COMPILATION REPORT

**The Arthur Home**  
**Provider #: 0005462**  
**09/01/2003 to 08/31/2004**

**Schedule 5A**

VI. Adjustment Detail  
Line 29 - Other

<u>Non-allowable expenses</u>	<u>Amount</u>	<u>Reference</u>
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**SEE ACCOUNTANTS' COMPILATION REPORT**

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number The Arthur Home

# 0005462

Report Period Beginning:

09/01/2003

Ending:

08/31/2004

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,656)	0	0	0	0	0	0	0	0	0	0	(3,656)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(3,656)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(3,656)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(17,597)	0	0	0	0	0	0	0	0	0	0	(17,597)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(17,597)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(17,597)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(2,529)	0	0	0	0	0	0	0	0	0	0	(2,529)	20
21	Clerical & General Office Expenses	(500)	0	0	0	0	0	0	0	0	0	0	(500)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(3,029)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(3,029)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(24,282)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(24,282)</b>	<b>29</b>



## STATE OF ILLINOIS

Summary B

Facility Name & ID Number    The Arthur Home#    0005462

Report Period Beginning:

09/01/2003    Ending:

08/31/2004

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,569)	0	0	0	0	0	0	0	0	0	0	(1,569)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(1,569)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,569)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(29,981)	0	0	0	0	0	0	0	0	0	0	(29,981)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(29,981)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(29,981)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(55,832)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(55,832)</b>	<b>45</b>

Facility Name & ID Number The Arthur Home# 0005462

Report Period Beginning:

09/01/2003

Ending:

08/31/2004

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Eberhardt Village	Arthur	Supportive
						Living
						Facility

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$			\$	\$	1
2	V				N/A				2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number      The Arthur Home      #      0005462      Report Period Beginning:      09/01/2003      Ending:      08/31/2004

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Gale Pearce	President of Board	Management	0.00	None	<1 hour	< 1%	N/A	\$ 0	N/A	1
2	H. D. Herschberger	Vice Pres of Board	Management	0.00	None	<1 hour	< 1%	N/A	0	N/A	2
3	Kenneth Borntrager	Board Member	Management	0.00	None	<1 hour	< 1%	N/A	0	N/A	3
4	Dave Conlin	Board Member	Management	0.00	None	<1 hour	< 1%	N/A	0	N/A	4
5	Rick Weger	Board Member	Management	0.00	None	<1 hour	< 1%	N/A	0	N/A	5
6	Paul Schrock	Board Member	Management	0.00	None	<1 hour	< 1%	N/A	0	N/A	6
7	Alva Miller	Secy-Treas of Board	Management	0.00	None	<1 hour	< 1%	N/A	0	N/A	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arthur Home# 0005462 Report Period Beginning: 09/01/2003 Ending: 8/31/2004

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_

Fax Number (\_\_\_\_) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3			N/A						3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arthur Home# 0005462

Report Period Beginning:

09/01/2003

Ending:

08/31/2004

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	State Bank of Arthur		X	Purchase of adjacent land	None	6/24/04	\$ 280,000	\$		0.0550	\$ 1,569	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 280,000	\$			\$ 1,569	9	
	B. Non-Facility Related*												
10								Offset income against expense			(1,569)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			(1,569)	14	
15	TOTALS (line 9+line14)						\$ 280,000	\$			\$	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

## B. Real Estate Taxes

<b><i>Important</i>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>							
1. Real Estate Tax accrual used on 2003 report.						\$	<b>1</b>
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)						\$	<b>N/A</b>
3. Under or (over) accrual (line 2 minus line 1).						\$	<b>3</b>
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)						\$	<b>4</b>
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>						\$	<b>5</b>
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.							
<b>TOTAL REFUND \$      For      Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>						\$	<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.						\$	<b>7</b>
Real Estate Tax History:							
Real Estate Tax Bill for Calendar Year:		1999	None	8			
		2000	None	9			
		2001	None	10			
		2002	None	11			
		2003	None	12			
Facility is a not-for-profit entity and does not pay real estate tax.							
Real estate tax paid on non-care assets has been eliminated on page 3 - column 7							

		<b>FOR OHF USE ONLY</b>		
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2003	\$		<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$		<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$		<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$		<b>16</b>

1. Please indicate a negative number by use of brackets ( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**SEE ACCOUNTANTS' COMPILATION REPORT**

**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

**2003 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME The Arthur Home COUNTY Moultrie

FACILITY IDPH LICENSE NUMBER 0005462

CONTACT PERSON REGARDING THIS REPORT Linda Butler, Business Office Manager

TELEPHONE 217-543-2103 FAX #: 217-543-2278

**A. Summary of Real Estate Tax Costs**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. Facility pays real estate taxes on		\$	\$
2. non-care assets. All costs are		\$	\$
3. adjusted out of the cost report.		\$	\$
4. _____		\$	\$
5. <u>03-03-25-425-007</u>	<u>4156 S. Oak</u>	\$ <u>1,661.20</u>	\$ None
6. <u>03-03-25-406-009</u>	<u>PT S1/2 SW1/4 SE1/4</u>	\$ <u>207.54</u>	\$ None
7. <u>03-03-25-406-003</u>	<u>Eberhardt Dr.</u>	\$ <u>151.20</u>	\$ None
8. <u>03-03-25-406-007</u>	<u>PT SW1/4 SE1/4</u>	\$ <u>5,910.40</u>	\$ None
9. <u>03-03-25-406-002</u>	<u>Eberhardt Dr</u>	\$ <u>3.00</u>	\$ None
10. _____		\$	\$
<b>TOTALS</b>		\$ <u>7,933.34</u>	\$ <u>-0-</u>

**B. Real Estate Tax Cost Allocation:**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? See above YES \_\_\_\_\_ NO \_\_\_\_\_

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

**C. Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,236 B. General Construction Type: Exterior Brick veneer Frame Concrete,steel,wood Number of Stories One

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

SEE PAGE 13 - Schedule F:

-Rental Property - Single family residential Property

-8.8 acres adjacent to nursing home to be used for Supportive Living Facility

-McMullen Young property adjacent to nursing home to be used for expansion

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO  
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A  
3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident care	152,469	1959	\$ 2,085	1
2					2
3	TOTALS	152,469		\$ 2,085	3

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name &amp; ID Number The Arthur Home

# 0005462

Report Period Beginning:

09/01/2003 Ending: 08/31/2004

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	40	1959	1959	\$ 124,966	\$	33	\$	\$	\$ 124,966
5	29	1975	1975	308,251	9,341	33	9,341		275,278
6									
7									
8									
<b>Improvement Type**</b>									
9	New roof	1972		1,988		10			1,988
10	Fire door - sprinkler	1973		25,066		10			25,066
11	Building improvement	1974		8,635		10			8,635
12	Remodeling	1976		4,899		10			4,899
13	Insulation	1977		3,094		10			3,094
14	Building improvement	1978		4,020		10			4,020
15	Seamless floors	1979		9,036		10			9,036
16	Building improvement	1979		4,228		10			4,228
17	Remodel kitchen	1980		12,772		10			12,772
18	Roof & building improvement	1981		24,368		10			24,368
19	Building improvement	1982		5,346		10			5,346
20	Heating system	1982		22,500		10			22,500
21	Building improvement	1983		8,453		10			8,453
22	Overhang	1983		2,210		10			2,210
23	New roof	1984		11,137		10			11,137
24	Remodel paint room	1985		1,214		10			1,214
25	New front door	1985		2,333		10			2,333
26	New bath/beauty shop	1986		13,969		10			13,969
27	Remodel med room	1986		1,886		10			1,886
28	Sprinkler system	1987		1,971	79	25	79		1,369
29	Fire doors	1987		1,097		10			1,097
30	Garage	1987		6,834	342	20	342		5,842
31	Boiler/furnace addition	1987		97,926	3,917	25	3,917		67,568
32	Floor replacement	1987		1,016	51	20	51		858
33	Water heater	1987		3,238		15			3,238
34	Garage wiring	1987		916	46	20	46		770
35	Floor replacement	1988		900	45	20	45		720
36									

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Doorways	1989	\$ 401	\$ 20	20	\$ 20	\$	\$ 312	37	
38	Sprinkler system	1989	2,523	111	25	111		1,594	38	
39	Patio	1989	2,384	119	20	119		1,825	39	
40	Replacement windows	1988	2,100	105	20	105		1,662	40	
41	Kitchen fire door	1989	1,005	40	25	40		593	41	
42	New flooring	1990	35,477	1,774	20	1,774		25,870	42	
43	Shower room/Basement remodel	1990	8,024	401	20	401		5,790	43	
44	Patient alarm	1990	3,172		10			3,172	44	
45	Curtain tracks	1991	679		10			679	45	
46	Door	1992	2,056		10			2,056	46	
47	Ramp	1992	6,007	240	25	240		3,000	47	
48	Gazebo	1992	10,636	532	20	532		6,606	48	
49	Sprinkler system	1992	22,385	895	25	895		11,044	49	
50	Building improvement	1992	1,560	78	20	78		949	50	
51	Remodel DON office	1993	3,970	199	20	199		2,255	51	
52	Air conditioner	1993	4,679		10			4,679	52	
53	Building improvement	1993	6,195	300	20	300		3,640	53	
54	Ramp, rails, heater	1994	8,030	401	20	401		4,312	54	
55	Roof work	1994	3,150	158	20	158		1,657	55	
56	Building improvement	1994	1,484	74	20	74		785	56	
57	Windows	1995	39,488	1,974	20	1,974		16,195	57	
58	Nurse call system	1995	10,082	1,008	10	1,008		9,576	58	
59	Water heater & bed lights	1995	4,664	467	10	467		4,594	59	
60	Flooring & doors	1995	3,187	159	20	159		1,457	60	
61	Hot water pipes	1996	2,576	129	20	129		1,096	61	
62	Shower room remodel	1996	1,707	85	20	85		694	62	
63	Lights	1996	1,366	68	20	68		539	63	
64	Air conditioners	1996	4,730	473	10	473		3,745	64	
65	Lavatory	1997	1,778	89	20	89		697	65	
66	Flooring	1997	15,671	784	20	784		5,945	66	
67	Recovering walls	1997	27,143	2,714	10	2,714		19,677	67	
68	Building improvement	1997	2,679	134	20	134		1,005	68	
69	Air conditioners	1998	6,751	675	10	675		4,613	69	
70	TOTAL (lines 4 thru 69)		\$ 962,008	\$ 28,027		\$ 28,027	\$	\$ 801,173	70	

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete

**09/01/2003 Ending: 08/31/2004**

**B. Building Depreciation-Including Fixed Equipment.** (See instructions.) Round all numbers to nearest dollar

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 962,008	\$ 28,027		\$ 28,027	\$	\$ 801,173	1
2	Miscellaneous improvements	1998	2,802	140	20	140		910	2
3	Basement steel	1998	4,639	232	20	232		1,489	3
4	Architectural fees	1998	10,950	548	20	548		3,516	4
5	Insulation	1998	3,600	180	20	180		1,080	5
6	Parking space	1999	1,596	64	25	64		363	6
7	Exhaust fan	1999	221	11	20	11		61	7
8	Install steel places over gutters	2000	484	24	20	24		118	8
9	Sink & faucet	2000	1,401	93	15	93		434	9
10	Ducts	2000	404	20	20	20		92	10
11	Basement doors	2001	1,058	53	20	53		194	11
12	Back doors	2001	2,687	134	20	134		436	12
13	Alarm system	2001	2,075	208	10	208		728	13
14	Ceiling improvement	2001	500	25	20	25		77	14
15	Grease trap	2001	2,531	127	20	127		381	15
16	New roof	2002	27,020	1,351	20	1,351		2,758	16
17	Miscellaneous improvement	2002	1,490	74	20	74		185	17
18									18
19	Fire sprinkler	2003	2,653	88	15	88		88	19
20	Cabinets	2004	3,926	196	10	196		196	20
21	Draperv & curtains	2004	4,110	206	10	206		206	21
22	Flooring & tile	2004	5,235	262	10	262		262	22
23	Sewer line replacement	2004	4,200	140	15	140		140	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,045,590	\$ 32,203		\$ 32,203	\$	\$ 814,887	34

**SEE ACCOUNTANTS' COMPILATION REPORT**

**\*\*Improvement type must be detailed in order for the cost report to be considered complete**

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 267,142	\$ 24,029	\$ 24,029	\$	5-15	\$ 154,338	71
72	Current Year Purchases	63,788	3,248	3,248		5-10	3,248	72
73	Fully Depreciated Assets	356,218					356,218	73
74								74
75	TOTALS	\$ 687,148	\$ 27,277	\$ 27,277	\$		\$ 513,804	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident care	1982 Ford Econovan	1986	\$ 7,000	\$	\$	\$	4	\$ 7,000	76
77	Resident care	1991 Ford Aerostar van	1991	15,110				4	15,110	77
78	Resident care	2001 Ford Supreme bus	2001	45,103	11,276	11,276		4	36,709	78
79										79
80	TOTALS			\$ 67,213	\$ 11,276	\$ 11,276	\$		\$ 58,819	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,802,036	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 70,756	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 70,756	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,387,510	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Donated farm land	\$ 22,500	\$	\$	86
87	Rental house-415 S. Oak-Arthur	86,862	2,735	22,639	87
88	8.8 acres farm land-Lutheran Ch.	81,771			88
89	McMullin-Young property	290,373			89
90					90
91	TOTALS	\$ 481,506	\$ 2,735	\$ 22,639	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ <u>N/A</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

\*\*

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease                     .

9. Option to Buy: ☐ YES ☐ NO Terms:                                      \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ N/A

Description: N/A

(Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:

Beginning                     

Ending                     

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.                      /2005 \$                     

13.                      /2006 \$                     

14.                      /2007 \$                     

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ <u>N/A</u>	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
--	--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
(c) For in-house training programs only. Do not include fringe benefits.  
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ \_\_\_\_\_

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.  
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A (3)	hrs	\$	4,583	\$ 29,552	\$	4,583	\$ 29,552	1
2	Licensed Speech and Language Development Therapist	10A (3)	hrs		135	1,157		135	1,157	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A (3)	hrs		6,907	49,217		6,907	49,217	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 (2)	# of prescripts				69,508		69,508	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	11,625	\$ 79,926	\$ 69,508	11,625	\$ 149,434	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 17

Facility Name &amp; ID Number The Arthur Home

# 0005462

Report Period Beginning: 09/01/2003

Ending:

08/31/2004

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 08/31/2004

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 305,374	\$ 305,374	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance -0- )	267,033	267,033	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	202,670	202,670	5
6	Prepaid Insurance	8,507	8,507	6
7	Other Prepaid Expenses	11,415	11,415	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Contributions Receivable</u>	313,900	313,900	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,108,899	\$ 1,108,899	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	396,729	2,085	13
14	Buildings, at Historical Cost	824,200	737,338	14
15	Leasehold Improvements, at Historical Cost	308,252	308,252	15
16	Equipment, at Historical Cost	754,361	754,361	16
17	Accumulated Depreciation (book methods)	(1,412,394)	(1,387,510)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Project Development Costs</u>	281,682	281,682	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 1,152,830	\$ 696,208	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 2,261,729	\$ 1,805,107	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 51,346	\$ 51,346	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,881	1,881	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	59,121	59,121	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,713	16,713	31
32	Accrued Real Estate Taxes(Sch.IX-B)	2,696		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See attached sch17A</u>	7,014	7,014	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 138,771	\$ 136,075	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 138,771	\$ 136,075	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 2,122,958	\$ 1,669,032	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 2,261,729	\$ 1,805,107	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)



**Name**                    **The Arthur Home**  
**Provider #:**        **0005462**  
**07/01/2003 to 08/31/2004**

**Schedule 17A**

Other Current Liabilities:  
Line 36 Other (specify):

Description	Amount
Accrued Provider Tax	6,313
Other Accrued Liabilities	701
Total	<u>7,014</u>

**SEE ACCOUNTANTS' COMPILATION REPORT**

## XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,554,347	1
2	Restatements (describe):		2
3	Prior year adjustment	4,052	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,558,399	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	232,459	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Temporarily restricted net assets	332,100	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 564,559	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,122,958	24 *

Operating Entity Only

\* This must agree with page 17, line 47.

**SEE ACCOUNTANTS' COMPILATION REPORT**

## STATE OF ILLINOIS

Page 19

Facility Name &amp; ID Number The Arthur Home

# 0005462

Report Period Beginning: 09/01/2003

Ending: 08/31/2004

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1			
	Revenue	Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,647,689	1
2	Discounts and Allowances for all Levels	(47,137)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,600,552	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	123,012	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 123,012	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,625	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	63,661	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,707	19
20	Radiology and X-Ray		20
21	Other Medical Services	58,759	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 129,752	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	4,105	24
25	Interest and Other Investment Income***	2,000	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 6,105	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See attached Sch 19A</u>	26,168	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 26,168	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,885,589	30

2			
	Expenses	Amount	
<b>A. Operating Expenses</b>			
31	General Services	626,071	31
32	Health Care	1,260,418	32
33	General Administration	557,049	33
<b>B. Capital Expense</b>			
34	Ownership	72,325	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	99,489	35
36	Provider Participation Fee	37,778	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,653,130	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	232,459	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 232,459	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

The Arthur Home  
Provider #0005462  
09/01/2003 - 08/31/2004

**Schedule 19A**

**Supplemental Schedule of Revenues**

<u>Description</u>	<u>Amount</u>
Arthur Home:	
Vending Income	31
Activity Income	4,362
Transportation Income	13,235
House Rent	4,050
Other Income	500
House & Farm Property:	
Rent - Farm Ground	2,220
Eberhardt Village:	
Gain on Equipment	790
Other Income	980
Total	<u>26,168</u>

**See Accountants' Compilation Report**

Facility Name &amp; ID Number The Arthur Home

# 0005462

Report Period Beginning: 09/01/2003

Ending: 08/31/2004

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,992	2,080	\$ 52,264	\$ 25.13	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,554	2,648	49,785	18.80	3
4	Licensed Practical Nurses	14,594	15,456	242,665	15.70	4
5	Nurse Aides & Orderlies	43,340	46,779	464,979	9.94	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,287	3,747	40,243	10.74	8
9	Activity Director	1,881	2,131	26,895	12.62	9
10	Activity Assistants	4,861	5,178	47,356	9.15	10
11	Social Service Workers	2,835	3,065	40,260	13.14	11
12	Dietician					12
13	Food Service Supervisor	2,008	2,242	25,758	11.49	13
14	Head Cook	1,082	1,313	13,698	10.43	14
15	Cook Helpers/Assistants	14,917	16,192	128,828	7.96	15
16	Dishwashers					16
17	Maintenance Workers	3,442	3,797	44,139	11.62	17
18	Housekeepers	5,509	6,557	73,842	11.26	18
19	Laundry	7,255	7,815	64,327	8.23	19
20	Administrator	1,912	2,080	73,839	35.50	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,682	2,066	37,035	17.93	23
24	Clerical	1,938	2,106	26,070	12.38	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,856	2,080	24,704	11.88	31
32	Other Health C (See Sch 20A)	6,933	7,579	116,815	15.41	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	123,878	134,911	\$ 1,593,502 *	\$ 11.81	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	129	\$ 5,021	1 (3)	35
36	Medical Director	Monthly	4,000	9 (1)	36
37	Medical Records Consultant	24	2,100	10 (3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	60	650	10 (3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	1,572	11 (3)	44
45	Social Service Consultant	48	1,572	12 (3)	45
46	Other(specify) Dental	12	1,200	10 (3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)	321	\$ 16,115		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	N/A	\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

**The Arthur Home**

**Provider #: 0005462**

**09/01/2003 to 08/31/2004**

**Schedule 20A**

XVIII: Staffing & Salary Costs

Line 32 Other Health Care (specify):

Description	Hours Worked	Hours Paid	Salary & Wages	Ave. Hrly. Wage
Care Plan Coordinator	2,176	2,336	51,157	21.90
Resident Care Coordinator	2,024	2,320	42,831	18.46
Unit Aide/Ward Clerk	2,733	2,923	22,827	7.81
	6,933	7,579	116,815	15.41

**SEE ACCOUNTANTS' COMPILATION REPORT**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes		F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount
Gary Coulter	Administrator	0	\$ 73,839	Workers' Compensation Insurance	\$ 31,500	IDPH License Fee	\$ 1,500
				Unemployment Compensation Insurance	15,343	Advertising: Employee Recruitment	5,012
				FICA Taxes	117,035	Health Care Worker Background Check	
				Employee Health Insurance	124,520	(Indicate # of checks performed 40 )	475
				Employee Meals		Illinois Health Care Association	3,726
				Illinois Municipal Retirement Fund (IMRF)*		Other tax & licenses	324
				Employee Physicals	173	Advertising	2,494
						Miscellaneous dues	165
						Miscellaneous subscriptions	156
TOTAL (agree to Schedule V, line 17, col. 1)							
(List each licensed administrator separately.)							
\$ 73,839							
B. Administrative - Other							

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

**The Arthur Home**  
**Provider #: 0005462**  
**09/01/2003 to 08/31/2004**

**Schedule 21A**

G. Schedule of Travel and Seminar\*\*

Total (agree to Schedule V, line 19, column 3) 0

Allocated from Management Company

Total (agree to Schedule V, line 19, column 8) 0

**SEE ACCOUNTANTS' COMPILATION REPORT**



**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2								N/A					
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union?    No
- (2) Are there any dues to nursing home associations included on the cost report?    Yes  
If YES, give association name and amount.    IL Health Care Assoc. - \$3,726
- (3) Did the nursing home make political contributions or payments to a political organization?    No    If YES, have these costs been properly adjusted out of the cost report?    N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?    No    If YES, what is the capacity?    N/A
- (5) Have you properly capitalized all major repairs and equipment purchases?    Yes  
What was the average life used for new equipment added during this period?    7.5 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.    \$ 10,709    Line 10 (2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?    Yes    If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement?    No  
If YES, give effective date of lease.    N/A
- (9) Are you presently operating under a sublease agreement?    YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?    YES    NO X    If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
- 
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period.    \$ 37,778  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?    No    If YES, attach an explanation of the allocation.

**SEE ACCOUNTANTS' COMPILATION REPORT**

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?    Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No    For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V.    \$ No    Has any meal income been offset against related costs?    Yes    Indicate the amount.    \$ 3,625
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel?    No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents?    No    If YES, please indicate the amount of income earned from such a program during this reporting period.    \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients?    Adequate records have been maintained.  
d. Have vehicle usage logs been maintained?    Adequate records have been maintained.  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?    Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?    None  
g. Does the facility transport residents to and from day training?    No  
Indicate the amount of income earned from providing such transportation during this reporting period.    \$ None
- (17) Has an audit been performed by an independent certified public accounting firm?    Yes  
Firm Name:    Altschuler, Melvoin and Glasser LLP    The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?    No    If no, please explain.    Will be submitted when completed
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?    Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?    N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	168,284	10,197	12,068	190,549	0	190,549	0	190,549
2. Food Purchase	0	121,750	0	121,750	0	121,750	-3,656	118,094
3. Housekeeping	73,842	10,804	1,100	85,746	0	85,746	0	85,746
4. Laundry	64,327	7,916	0	72,243	0	72,243	0	72,243
5. Heat and Other Utilities	0	0	61,768	61,768	0	61,768	0	61,768
6. Maintenance	44,139	0	49,876	94,015	0	94,015	0	94,015
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	350,592	150,667	124,812	626,071	0	626,071	-3,656	622,415
9. Medical Director	0	0	4,000	4,000	0	4,000	0	4,000
10. Nursing & Medical Records	991,455	54,105	4,172	1,049,732	0	1,049,732	0	1,049,732
10a. Therapy	0	0	79,926	79,926	0	79,926	0	79,926
11. Activities	114,511	9,105	3,144	126,760	0	126,760	-17,597	109,163
12. Social Services	0	0	0	0	0	0	0	0
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	1,081,262	63,210	91,242	1,235,714	0	1,235,714	-17,597	1,218,117
17. Administrative	73,839	0	0	73,893	0	73,839	0	73,839
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	15,261	15,261	0	15,261	0	15,261
20. Fees, Subscriptions & Promotion	0	0	13,377	13,377	0	13,377	-2,054	11,323
21. Clerical & General Office	63,105	16,413	16,276	95,794	0	95,794	-975	94,819
22. Employee Benefits & Payroll	0	0	288,571	288,571	0	288,571	0	288,571
23. Inservice Training & Education	0	0	0	0	0	0	0	0
24. Travel and Seminar	0	0	10,419	10,419	0	10,419	0	10,419
25. Other Admin. Staff Trans	0	0	0	0	0	0	0	0
26. Insurance-Prop.Liab.Malpractice	0	0	59,788	59,788	0	59,788	0	59,788
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	161,648	16,413	403,692	581,753	0	581,753	-3,029	578,724
29. Total General Administrative	1,593,502	230,290	619,746	2,443,538	0	2,443,538	-24,282	2,419,256
30. Depreciation	0	0	70,756	70,756	0	70,756	0	70,756
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	1,569	1,569	0	1,569	-1,569	0
33. Real Estate	0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	0	0	0	0	0	0
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	72,325	72,325	0	72,325	-1,569	70,756
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	69,508	0	69,508	0	69,508	0	69,508
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	37,778	37,778	0	37,778	0	37,778
43. Other (specify):*	0	0	29,981	29,981	0	29,981	-29,981	0
44. Total Special Cost Ce	0	69,508	67,759	137,267	0	137,267	-29,981	107,286
45. Grand Total	1,593,502	299,798	759,830	2,653,130	0	2,653,130	-55,832	2,597,298

	After	
	Operating	Consolidation
General Service Cost Center		
1. Cash on hand and in banks	305,374	305,374
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	267,033	267,033
4. Supply Inventory	0	0
5. Short-Term Investments	202,670	202,670
6. Prepaid Insurance	8,507	8,507
7. Other Prepaid Expenses	11,415	11,415
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	313,900	313,900
10. Total current assets	1,108,899	1,108,899
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	396,729	2,085
14. Buildings, at Historical Cost	824,200	737,338
15. Leasehold Improvements, Historical Cost	308,252	308,252
16. Equipment, at Historical Cost	754,361	754,361
17. Accumulated Depreciation (book methods)	-1,412,394	-1,387,510
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	281,682	281,682
24. Total Long-Term Assets	1,152,830	696,208
25. Total Assets	2,261,729	1,805,107
CURRENT LIABILITIES		
26. Accounts Payable	51,346	51,346
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	1,881	1,881
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	59,121	59,121
31. Accrued Taxes Payable	16,713	16,713
32. Accrued Real Estate Taxes	2,696	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	7,014	7,014
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	138,772	136,076
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	0
46.Total Liabilities	138,772	136,076
47.Total Equity	2,122,957	1,669,031
48.Total Liabilities and Equity	2,261,729	1,805,107

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,647,689
2. Discounts and Allowances for all Levels	-47,137
Subtotal - Inpatient Care	2,600,552
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	123,012
7. Oxygen	0
Subtotal - Ancillary Revenue	123,012
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	3,625
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	63,661
18. Sale of Supplies to Non-Patients	0
19. Laboratory	3,707
20. Radiology and X-Ray	0
21. Other Medical Services	58,759
22. Laundry	0
Subtotal - Other Operating Revenue	129,752
24. Contributions	4,105
25. Interest and Other Investments Income	2,000
Subtotal - Non-Operating Revenue	6,105
27. Other Revenue (specify):	30,218
28. Other Revenue (specify):	0
Subtotal - Other Revenue	30,218
30. Total Revenue	2,889,639
31. General Services	626,071
32. Health Care	1,235,714
33. General Administration	581,753
34. Ownership	72,325
35. Special Cost Centers	99,489
35. Provider Participation Fee	37,778
37. Other	0
40. Total Expenses	2,653,130
41. Income Before Income Taxes	236,509
42. Income Taxes	0
43. Net Income or Loss for the Year	236,509

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